

Florida
Integrated Collaborative Casework Practice: Screening and
Assessment - Minimum Standards for Screening and Assessment

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INTEGRATED COLLABORATIVE CASEWORK PRACTICE SCREENING AND ASSESSMENT

RECOMMENDED PRACTICE

The Statewide Steering Committee workgroup for Product #2, Screening and Assessment of individuals and families for substance abuse within the child welfare system, proposes the following state guidelines for screening and assessment.

Screening for Substance Abuse

The Child Protective Investigator, using the Child Safety Assessment, determines that substance abuse is a contributing factor to child maltreatment. The investigator on-site generates a referral for a substance abuse screening to a licensed substance abuse provider, preferably a Family Intervention Specialist, (FIS), who will assist the PI with an on-site screening. The on-site screening should include an assessment of the client's level of motivation to participate in treatment utilizing a *stages of change* model.

The Crisis Response Team is an intensive, multi-faceted, in-home crisis stabilization service with immediate-response capabilities. This program features a single point of coordination that allows Protective Investigators to readily access crisis services, which provide on-site response within 120 minutes. With this service, child protective investigators have improved resources at their disposal that allow them to keep children safely in their own homes.

When a family is in the midst of a crisis that jeopardizes a child's safety, CPIs in the field have the ability to call a single access number and speak with a Prevention Coordinator. Based on the nature of the crisis, the Prevention Coordinator will deploy a Crisis Response Team Counselor to the scene who will intervene to stabilize the situation.

In addition to clinical intervention, this program is able to meet immediate needs through the availability of "flex funds". Flex funds are used to pay for home repairs, rent, utilities, transportation costs, and other material needs that will enable families to stay intact in a time of crisis.

The Crisis Response Team stays connected to other critical components of the system of care. The Prevention Coordinator is available to assist the CPI in service initiation, and attends the Early Service Intervention staffing once scheduled, to provide pertinent information and assist in case planning. If the family is already in services with CBC, the Prevention Coordinator is available to consult with the CBC case manager as well.

Each week, CRT staffing is held to monitor the progress of families served in working toward family stability. The team of professionals working with the family meet at this

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time, including the Prevention Coordinator, CPI (if applicable), CBC Case Manager (when assigned), and service providers. The family is invited to participate as well.

The family will continue to be staffed until the team decides that sufficient stability has been achieved and needed services have been established. The Crisis Response Team brings together the collective expertise of many of the community's most well-established service agencies.

CBC's are a potential source for ongoing funding of a Crisis Response Team. CBC's currently spend significant resources per month in out-of-home care. If effective, the Crisis Response Team will decrease the out of home care population, thereby decreasing this cost to CBC's. These cost savings are then used to support the continuation of this program.

When child safety is immediately compromised, a crisis response team should be assembled to assist the family in planning for immediate in-home services or an out-of-home placement. The PI must be able to determine the existence of other potential co-occurring problems in order to assemble the correct team, ie domestic violence or mental health, as examples. This indicates the need for additional cross-training of PI's, substance abuse and FIS staff on markers of substance abuse, other co-occurring disorders and the *stages of change* that substance abusers experience.

Family Intervention Specialists, (FIS), or other substance abuse licensed agency staff, function as active on-call members of the Crisis Response Team. Other members of the CRT team may also advise the Protective Investigator (PI) to contact a FIS for substance abuse screening and intervention when the need is identified.

The CRT member and the FIS should have flex dollars available to assist in stabilizing the family, and in breaking down barriers to treatment. With the "no wrong door" initiative in the State of Florida, the CRT and FIS, is in a position to access all of the services that an individual will need to have a successful long term outcome because of the on-going involvement with the entire family. This includes participation, as it is developed, with the Family Team Conferencing Model.

When the PI determines that there is no immediate danger of removal, and a CRT response is not required, but has determined that substance abuse is impacting the family, the PI should contact a FIS to provide on-site screening within 72 hours. The FIS will case manage and advocate for entry into the substance abuse treatment system.

The FIS staff, along with other CRT members and community providers, should regularly attend ESI staffings to provide information regarding the need for behavioral health services, and to provide referral information.

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The FIS staff should work with the family for an average of 3 months, and never less than 30 days, to assure that the family is successful, and able to successfully achieve the substance abuse case plan goals. During this time, the FIS meets regularly with those involved in the family's treatment and specifically with the community based care case manager to assure that substance abuse case plan goals are met.

Agreements with other providers should be established to ensure participation on a crisis response team, with protocols for mobilizing the team. All responders should be trained in the *family conferencing model*. The team assists the family in determining immediate needs for the use of flexible funds to stabilize the family. The team assists with immediate planning to engage the family when out of home placement of children is needed.

ASSESSMENT OF FAMILY MOTIVATION – STAGES OF CHANGE

It is critical at the first contact with the family to assess the motivation to change, as well as to become an impetus to encourage change within the family. The Stages of Change Model has existed within the substance abuse treatment community for a number of years and is adaptable across disciplines in assessing family motivation to change. The Model was developed by Prochaska and DiClemente, et al, 1992. The tenants to stages of change involve the following:

- ***Precontemplation*** – Not seeing the behavior as a problem or not wanting to change the behavior. This is sometimes characterized as “denial”.
- ***Contemplation*** – Beginning to understand that the behavior is causing difficulties in living or taking a toll on health and happiness.
- ***Preparation/Determination*** – Considering various options for change.
- ***Action*** – Taking concrete steps to change the behavior in a specific way.
- ***Maintenance*** – Avoiding relapse into problem behavior.
- ***Relapse*** – Slipping back into problematic use or abuse.

From SAMHSA TIP 24: Most families are in one of the first three stages and can be expected to express ambivalence or resistance to change. This is why it is crucial for the collaborative team to work toward motivation of the family, even at the first contact. Motivation Enhancement Therapy with cognitive behavioral approaches and community reinforcement can assist in this process. A community reinforcement approach could be the use of the FIS who can present to the family the opportunity to break down those barriers which impede treatment. This could include discussion of those tangible items such as assistance with transportation, child care, job seeking, and perhaps a security deposit which have placed added stress on the family. The family would ideally see the team as supportive and helpful, and not about removing the child from their custody.

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Engagement and Strength Based Practice

The focus of investigators is gathering evidence for purposes of proving that child maltreatment occurred and/or that child removal is needed. Investigators must also determine which services are needed, including court supervision of the family. The focus of service interveners is generally on the individual problems of children or caregivers. Goals of case plans and treatment plans should be stated in terms of family goals utilizing the *family conferencing model*. The family's support system should also be involved in case planning.

The focus of investigators is an assessment of family needs related to health, safety, and sobriety that compromise child safety for purposes of creating the right family team to assist with case planning. The investigator, with the assistance of a FIS or crises response team, should begin the process of identifying family *strengths, needs, abilities and preferences*. (SNAP)

Service interveners should continue to leverage child and family strengths, abilities, and preferences in order to help children and families succeed in achieving their goals. Cross-system training on engagement, motivation, stages of change, including relapse, and strength-based practice should be continuously trained.

Comprehensive Behavioral Assessment

A family systems view of the child and family should be obtained. Input from other family members/friends should be obtained and incorporated into the assessment. Parents should be asked what their goals are, what strengths and resources exist within the family, and what they view as their needs. Areas needing attention for successful participation in services should be addressed, e.g. is transportation, cost, child-care, or scheduling a problem that might impede the parent or caregiver.

A protective investigator and a FIS, or a crises response team conducts an initial screening assessment. Subsequent assessment needs are the result of decisions made by the family team.

The team, including the parents and their chosen support persons, develop **a common perspective of the child and family's situation, their goals, strengths, resources and needs**. The team shares and analyses all assessment information. The team, with the family, achieves consensus about the implications of assessment information. Special efforts should be made to assess the needs of incarcerated parents, and as appropriate, to involve them in team meetings.

The team develops a common understanding of what the child and family will need in order to achieve their goals, including the type of assistance needed to access services. The team understands the child and family's culture, and is able to identify and offer culturally appropriate choices. The team is able to effectively screen children who may need a neurological evaluation based upon potential substance use during pregnancy.

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Cross-system training on the broader concept of functional assessments, screening for neurological disorders in children, and achieving agreement on assessment information through the family team meeting process, will be needed.

What has been cited as best practice in the SAFERR manual, is the importance of cross-training staff in basic screening of SA, MH, and DV issues within families. The *use of a screening tool is less important*, than the training and competence level of staff. Formalized screens may be useful in training staff to look for key indicators when initially responding to an abuse report. For the SA, MH, or DV Professional, this cross-training in the identification of co-occurring problems within the family which impair the family functioning is imperative. Service providers must be flexible in approaches that go above and beyond the current status quo. Observational markers of SA, DV, and MH should be trained with all CW and Provider staff.

Case planning is ineffective without a functional family assessment that is sensitive to the traditional and current values and belief systems of major ethnic groups. Family dynamics, including relationships and roles within the family, the power structure and communication within the family, and the assessment of functional and dysfunctional patterns are critical in targeting the areas where the family will require the greatest assistance.

The *Comprehensive Behavioral Assessment* should be integrated with the bio-psychosocial substance abuse assessment and augmented with the family functional assessment. This has been implemented as a pilot within the District 12 Family Drug Court for those with a confirmed substance abuse diagnosis with positive results. This should be reimbursed by Medicaid and accepted by the courts for those with involvement in the child welfare system with a confirmed substance abuse diagnosis. It provides for implementation of case plans which are valid, more timely, and do not duplicate the costs of more extensive assessments when not warranted. While screening is completed by bachelors level trained counselors under supervision, the *Comprehensive Behavioral Assessment* should be performed by Masters Level Licensed or Certified Addiction Professionals.

From the *Comp Behavioral Assessment*, the family determines individualized long-range goals, and based on those goals, who needs to participate on their family team. The caseworker helps the family identify both formal and informal persons to serve on the team. When a family is not able to identify a family member or friend, the caseworker helps them identify person(s) who have the potential to become sources of support.

The family team helps the family develop a plan to achieve the family goals. The team works with the family to identify their strengths and resources that will be leveraged to achieve goals. Steps that are needed to achieve goals are carefully sequenced, and ensure

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that the family is able to succeed with each step. If there are conditions or requirements of probation or parole, they are including in the team's planning.

Team meetings drive the service planning process. The formal and informal system persons that are needed to help the child and family achieve success are at the team meetings. Each meeting results in next steps and responsibilities of all team members, including the family. When other caregivers for the children are needed (relatives or foster care), these caregivers will be involved on the family's team. Additionally, partnership agreements need to be established with other stakeholders to ensure their participation in family conferences and training.

CHILD AND FAMILY TEAMS

The wraparound process is a way to improve the lives of children and families who have complex needs. It is not a program or a type of service. The process is used to help families develop individualized plans of care. The actual individualized plan is developed by a Child and Family Team, the four to ten people who know the child best, including the child and family. The team should be no more than half professionals.

The plan is needs- driven rather than service driven, although a plan may incorporate existing categorical services if appropriate to the needs of the child and family. The initial plan is a combination of existing or modified services, newly created services, informal supports or natural supports, and community resources, and includes a plan for a step-down of formal services.

This plan is family centered rather than child centered. The parent(s) and child are integral parts of the team and must have ownership of the plan. No planning sessions occur without the presence of the child and family.

The plan is based on the unique strengths, values, norms, and preferences of the child, family and community. No interventions are allowed in the plan that do not have matching child, family, and community strengths.

The plan is focused on typical need in life domain areas that all persons (of like age, sex, culture) have and include; family, living situation, financial, educational/vocational, social/recreational, behavioral/emotional, psychological, health, legal, cultural, safety, and others.

All services and supports must be culturally competent and tailored to the unique values and cultural needs of the child, family, and the culture with which family identifies.

The child and family team and agency staff who provide services and supports must make a commitment to unconditional care. When things do not go well, the child and family are not "kicked out", but rather, the individualized services and supports are changed.

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Services and supports are community-based. When residential treatment or hospitalization is assessed, these service modalities are to be used as resources and not as placements that operate outside of the plan produced by the child and family team.

Planning, services, and supports cut across traditional agency boundaries through multi-agency involvement and funding. Outcome measures are identified and the plan should be evaluated often.

Effective Teamwork Coordination

Relapse planning is often included in the substance abuse treatment plan, and should be part of the child welfare plan. The substance abuse and child welfare professional should tell the parent that relapse sometimes occurs and must be planned for if this happens. This should not necessarily result in Termination of Parental Rights.

All major decisions should occur at team meetings, and reflect consensus among team members. The team works to promote trust, respect and honesty among all team members. The case manager works with the family and team members to determine when team meetings are needed, and who should attend. The team should be skillful in addressing the safety needs of victims of domestic violence and in planning team meetings accordingly. Often, team meetings will occur separately with the victim.

All team members should understand the family's goals, strategies to achieve goals, and their current status throughout the course of the case.

Efforts are made to hold team meetings at times and places conducive to meeting attendance by the family and other key partners. When key persons are not able to attend, the case manager ensures that knowledge and information from the missing team member(s) is shared before and after the meeting.

The child and family should be able to provide feedback to the team on an ongoing basis as to what is working or not working for them. The team should be open and responsive in making changes to the case plan. This includes requesting changes to court ordered services when needed.

Relapse planning should always be a component of the child welfare and substance abuse treatment plans. The plans should be consistent, and complimentary, in relapse planning as well as other issues.

The family's support system should be involved and actively participating in the child and family's recovery by participating on the family team. Alternative caregivers, whether relatives or foster parents, should be involved on the team and working to support the child and family's recovery.

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Training for alternative caregivers (relatives and foster parents) will need to be provided on engagement, motivation, stages of change, and strength-based practice. For relative caregivers, this training might occur through their participation on family teams.

Agreements with other system providers also need to address partnership willingness to respond to child and family feedback, including the possibility that current service interventions need to change.

Substance Abuse Treatment Services

Treatment provider (or the FIS) should participate on a family team. The substance abuse professional will engage with the team in assessing the family system as part of the *comprehensive behavioral and family functional assessment*, and the impact that recovery will have on other family members. The treatment provider will help the team understand the stages of change with recovery, including the person's current stage and likelihood of relapse. The provider should also help the team understand the intensity and duration of treatment needed, and the particular challenges related to the specific type of substance abuse.

The team will help the family identify all treatment choices, including AA, faith-based recovery options, and formal treatment providers. When residential treatment is needed but not available, the team will create an alternative strategy that allows for "in-home care" based on other community services such as AA, faith-based models, and outpatient services.

Substance abuse providers, including the FIS, will need training related to their new roles in the context of family teams. Cross training with child welfare staff on the family team model will also be recommended.

Substance abuse intensive outpatient capacity will need to be strengthened across the State. More capacity will be needed to provide Brief Motivational Interviewing and Solution Focused Brief Therapy. Substance abuse treatment capacity needs to be expanded to include child abuse, trauma and co-occurring issues. Substance abuse and child welfare partnerships with local AA and faith-based recovery programs will need to be strengthened.

Informal Services

Current child welfare case plans rarely address the support needs that children and families have to participate in treatment or achieve other case plan goals. Plans do not address the need to establish an informal support network and/or to build the capacity of a family's support network.

Family teams should include extended family members and/or friends who will support the child and family through the process of treatment and recovery. Through

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participation on the team, the family's informal support network contributes to the ongoing assessment of the family's needs. They also learn how they can assist the family.

The team helps the family identify the specific supports needed in order to participate in treatment or other strategies/interventions. For example, if transportation is a problem, assistance from the informal support network will be explored.

Child mentors need to be able to help children succeed in school, in social activities, in sports, hobbies or other pursuits. Informal and non-traditional community sources of support need to be cultivated. A pool of community members needs to be developed who are willing to participate on family teams and become sources of support to families.

Successful Transitions and Aftercare

When treatment is completed and children are reunified, there is generally a period of six months of supervision by the child welfare caseworker. Usually, ongoing random drug screening is the only means to measuring sustained progress.

The family team assesses the child and family needs for assistance and support after treatment has been completed. Aftercare planning will continue to address the child and family's health, safety and sobriety. Aftercare planning may include a combination of formal and informal supports for the caregiver who is recovering, based on their cultural preferences.

Aftercare planning addresses the significant changes for other family members, and identifies appropriate support strategies. The team should determine when the formal involvement of the child welfare and substance abuse treatment systems are no longer needed.